DR. NORMAN JONES, JR., NATIONAL PRESIDENT, Blinded Veterans Association

BLINDED VETERANS ASSOCIATION

TESTIMONY
PRESENTED BY

DR. NORMAN JONES, JR.
BVA NATIONAL PRESIDENT

BEFORE A JOINT SESSION OF THE
HOUSE AND SENATE COMMITTEES
ON VETERANS AFFAIRS

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## INTRODUCTION

Mr. Chairman and Members of the House and Senate Committees on Veterans Affairs, on behalf of the Blinded Veterans Association (BVA), thank you for this opportunity to present our legislative priorities. BVA is the only Congressionally chartered Veterans Service Organization exclusively dedicated to serving the needs of our Nation's blinded veterans and their families. Later this month, BVA will celebrate its 63rd anniversary of continuous work and service to this most unique group of Americans. We are especially proud of the close working relationship and strong support we have enjoyed from these Committees through the years. As a new generation of blinded veterans returns from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), our combined efforts will be extraordinarily important in ensuring that these new veterans, and those from previous conflicts and wars, have the full continuum of high-quality, accessible care and benefits they have earned. BVA greatly appreciated the strong bipartisan support of Members in helping to pass the "Dr. James Allen Disabled Veterans Equity Act" (H.R. 797) legislation in December. BVA is also grateful for passage of the "Vision Impairment Specialists Training Act" (H.R. 1240). Known also by the acronym VISTA, H.R. 1240 would help remedy the difficulty in recruiting new graduates of university programs specializing in Orientation & Mobility (O&M) by offering students scholarships in exchange for a commitment to work for VA immediately following graduation. BVA requests that the Senate Committee enact companion bill S. 1672 as quickly as possible.

## SEAMLESS TRANSITION ISSUES

During the past year, BVA has worked with Members of these two Committees as well as the two Armed Services Committees regarding the many problems associated with battle eye-injured and the TBI-wounded in the Seamless Transition process. Many severely eye-injured, now visually impaired, OIF and OEF returning service members are not centrally tracked, making it impossible for them to be referred to VA Blind Rehabilitation Service (BRS) in a timely manner. This failure negatively affects their access to the full continuum of blind inpatient and outpatient rehabilitation programs. They have similar trouble accessing highly specialized low-vision treatment clinics. BVA again stresses that, according to Department of Defense (DoD) data compiled between March 2003 and December 2007, a full 16 percent of all combat-injured casualties evacuated from Iraq had associated eye injuries. This is the highest percentage since the Civil War. BVA has become increasingly frustrated with the lack of cooperation even today between some DoD Medical Treatment Facilities (MTFs) and VA BRS in the reporting of eye injury cases. For this reason, BVA is sincerely grateful for the enactment of the Military Eye Trauma Center of Excellence and Registry legislation within the Wounded Warrior section of the National Defense Authorization Act (NDAA) of 2008.

Service members with severe eye injuries will need VA specialized blind rehabilitation services for decades but DoD, sadly, is a stumbling block in critical early delivery of these services. Early intervention is vital to beginning the adjustment necessary to adapt to life as a legally blinded or low-vision veteran. The intervention must not be unduly delayed by bureaucracy or lack of electronic exchange of medical records. BVA believes that the current DoD/VA Seamless Transition process associated with eye trauma cases is, at best, dysfunctional. We request that the Committees provide strong oversight on the implementation of the Military Eye Trauma Center of Excellence and Eye Trauma Registry.

TRAUMATIC BRAIN INJURY

As of December 14, 2007, Defense Veterans Brain Injury Center (DVBIC) reported 4,127 TBI wounded. Most of the wounded were exposed to Improvised Explosive Device (IED) blasts. As of January 10, 2008, a total of 39,298 service members had been wounded or injured in Iraq. The number wounded requiring air medical evacuation from Iraq between March 19, 2003 and January 10, 2008 was 8,761, of which an estimated 1,200 had sustained combat eye trauma. The number of direct battle eye injuries does not include a recently estimated 4,000 TBI service members or veterans who, if tested by either neuro-ophthalmologists or low-vision optometrists, could be diagnosed with neurological vision dysfunction in conjunction with their mild, moderate, or severe TBI.

Blast-related injury is now the most common cause of trauma in Iraq. BVA testified last year in favor of the creation of a TBI Center of Excellence and Post Traumatic Stress Disorder (PTSD) Center of Excellence. Lumping together the Military Eye Trauma Center of Excellence with the two other centers is essential and would strengthen military and VA care for the wounded. BVA believes that the Eye Trauma Center is where vital research, best practices, and outcome measures can be developed and refined.

We predict that the number of TBI-injured will continue to rise. Improvements in TBI rehabilitation must therefore be made in the area of TBI research, vocational and educational benefits, adaptive housing, long-term medical care, and family and caregiver programs. The

same is true for quality of life issues such as disability compensation and unemployment coverage for service members suffering from TBI.

## POST-TRAUMATIC VISION SYNDROME

Some TBIs result in legal blindness and other manifestations diagnosed as Post-Traumatic Vision Syndrome (PTVS). The VA Polytrauma Center in Palo Alto has reported that 80 percent of all TBI patients in its facility have complained of visual symptoms as a result of their exposure to TBI. Studies have further revealed that approximately 63 percent of the same group suffer from associated visual disorders of diplopia, convergence disorder, photophobia, ocular-motor dysfunction, color blindness, and an inability to interpret print. Although we commend VA for increased efforts recently to improve the continuing education of all clinical VA staff on the identification, diagnosis, and appropriate consultative management of TBI veterans, still more screening is needed. Continued support for vital TBI research is also a must, as is the enforcement of mandatory tracking of all service members who have sustained a mild to moderate TBI diagnosis. We believe that the severe cases are the most critical but that tracking should not be limited to them only.

Some 42 percent of the OIF wounded belong to the National Guard or Reserves. Many of these service members originate from communities of less than 20,000 inhabitants. BVA believes that some of the eye-injured from this group have been lost and not referred for VA follow-up, especially if they have been sent for Tricare services through National Guard or Reserve Community Health-Based Care Organization (CHBCO) programs. We request that Chairman Mitchell's Subcommittee on Oversight work with both the Armed Services Personnel Subcommittee and GAO in investigating Seamless Transition when there are traumatic visual injuries and TBI-related Post-Traumatic Vision Syndrome.

Service members who have suffered visual TBI injuries deserve the "Full Continuum of Care" through VA BRS and Low-Vision Services. The numbers previously cited should highlight and make very obvious to Members of these Committees that a new generation of visually impaired and blinded veterans is returning from OIF and OEF operations with unique TBI-related visual problems, PTVS neurological injuries, and direct eye trauma from IEDs. The failure to administer a proper and timely diagnosis of TBI and to appropriately treat its accompanying vision dysfunction may prevent such veterans from performing basic activities of daily living, resulting in increased unemployment, inability to succeed in future educational programs, greater dependence on government assistance programs, depression, and other psychosocial complications.

## ELECTRONIC HEALTH RECORDS

BVA is very concerned about the lack of substantial progress in the area of health care records exchange. We believe that DoD and VA must speed up the development of electronic medical records that are interoperable and bi-directional, allowing for a two-way electronic exchange of all health care clinical records and occupational/environmental exposure data, not just outpatient

data. We applaud DoD for beginning to collect medical and environmental exposure data electronically while military personnel are still in theaters of operation. The complete inpatient and outpatient electronic medical records should include an easily transferable and electronic DD-214 that can be forwarded from DoD to VA. Such a breakthrough would allow VA to expedite the claims process and give the service member faster access to health care and other benefits.

The Joint Electronic Health Records Interoperability (JEHRI) plan, agreed to by both VA and DoD through the Joint Executive Council, must be accelerated. The ultimate result will be the bi-directional exchange of interoperable health information. The first two phases of implementation have met with some success, but BVA believes that a fully integrated bi-directional system of electronic health records should already exist. In addition, technology is not wholly under the control of either department. Therefore, both of the respective Congressional Committees with oversight, VA and Armed Services, must demand these standards. BVA is not encouraged by reports that the timeline for full implementation has been moved from 2007 to 2010.

## FUNDING VHA BLIND REHABILATIION SERVICE

Combat-related eye injuries in Iraq and Afghanistan, and an aging veteran population with the known prevalence of age-related visual impairment, are the reality in 2008. Consequently, the VA Visual Impairment Advisory Board (VIAB) has identified and stressed the need for a uniform national standard for the full continuum of outpatient vision rehabilitation services. BVA was pleased with Secretary Nicholson's January 25, 2007 announcement that VHA would dedicate $40 million toward implementation of this Continuum of Care at 54 VA medical centers in order to improve access and decrease waiting times for both blinded and low-vision veterans. We appreciated also the fact that the 110th Congress included $12.5 million for FY 2008 for the vital implementation of these new outpatient blind and low-vision programs. Nevertheless, the FY 2009 proposed VHA budget includes an increase of only $6 million, far less than the necessary $14.5 million that was promised so that progress could continue. We therefore request that Congress include this amount in its appropriations.

## VA FUNDING FY 2009

The past few months were much like those of past years with respect to the discretionary budget process. On October 1, VA did not have the FY 2008 appropriation necessary for its new budget cycle. It became business as usual as medical center directors and chiefs of staff stopped hiring, could not purchase or repair equipment, and halted or slowed down needed local construction projects while again waiting for their budgets. BVA was pleased that the FY 2008 appropriations matched the recommendations of the VSO Independent Budget for the first time in 14 years, validating the group's analysis and budget projections. Shortfalls have occurred because funding models have not adequately accounted for the increased costs associated with the aging population of veterans and those associated with the rising numbers of OIF/OEF veterans entering the system.

The same phenomenon is occurring in the new FY 2009 budget cycle. VA is, for example, projecting that only 39,000 new OIF/OEF veterans will enroll. BVA is deeply concerned that the

currently high troop surge levels, longer deployments, and additional activated National Guard and Reserves will result in surprisingly higher enrollments than expected and larger funding deficits.

For FY 2009, the Bush Administration has requested $41.2 billion for veterans health care, a $2.2 billion increase over the FY 2008 appropriation. This is nevertheless a shortfall of $1.6 billion from the Independent Budget recommendation. Although we recognize that the large increases for FY 2008 were a step forward, we believe that the most viable long-run solution is to replace the current discretionary system with a methodology that provides for "sufficient, timely, and predictable" funding models. The tangle of Continuing Resolutions, supplemental appropriations, inaccurate enrollment costs for aging veterans, and constant tinkering to adjust for increasing numbers of injured war veterans entering the system must stop. Each year, the VA budgets approved by the Office of Management and Budget have subsequently revealed inaccuracies in what was really needed. The Independent Budget, on the other hand, has been much more reliable. We request a different health care funding methodology that will eliminate these shortfalls.

## VISION IMPAIRMENT SPECIALIST TRAINING ACT (VISTA), H.R. 1240

Although Public Law 104-262, The Eligibility Reform Act of 1996, requires VA to maintain its capacity to provide specialized rehabilitation services to disabled veterans, the Department cannot do so when there are not enough specialists to address these needs. With passage of legislation in December 2006 that increased the number of Blind Rehabilitation Outpatient Specialists (BROS) by 35 nationwide, there are an insufficient number of counselors certified in blind rehabilitation to provide for the growing number of blind or low-vision veterans, let alone the rest of our nation's elderly population.

As mentioned in our introduction, BVA appreciated passage of a bill introduced in the House by Representative Sheila Jackson Lee last June. The Vision Impairment Specialists Training Act (VISTA), or H.R. 1240, helps remedy this situation by directing the VA Secretary to establish a scholarship program for students seeking a degree or certificate in blind rehabilitation (Vision Impairment and/or Orientation and Mobility). VA testified in favor of this legislation. The discretionary scholarship program will provide an incentive to students who are preparing for work in this vital occupation and who would consider entry into VA employment. Because such training is necessary to help veterans function independently, we request that the Senate pass equivalent legislation, S. 1672, as soon as possible.

## BLIND VETERANS FAIRNESS ACT, H.R. 649

New York, New Jersey, Pennsylvania, and Massachusetts currently provide a yearly annuity for blinded veterans who have sustained a total loss of sight as a result of service in any war. Blinded veterans in New York currently receive an annual payment of $1101. The figure is $750 in New Jersey, $1,800 in Pennsylvania, and $2,000 in Massachusetts. Under current law, however, such blinded veterans actually lose part of their VA pension benefits for receiving this modest annuity from the aforementioned states. Other state legislatures such as Ohio, where the annuity is

currently being considered, will face this same problem unless corrected legislatively. A blinded veteran's VA pension should not be offset when such state annuities have been instituted.

H.R. 649 passed with bipartisan support in the First Session of the 110th Congress so that blinded veteran annuities would not be considered Social Security Income. Specifically, the new provision allows for annuities paid by states to blinded veterans to be "disregarded in determining Social Security Income benefits." Currently, those receiving these small state annuities are frequently disabled veterans with very low incomes. To penalize blinded veterans in this category by offsetting their VA pensions is entirely unfair to those who selflessly served our Nation. BVA requests Senate legislation to rectify the current injustice.

## VBA CLAIMS BACKLOGS REMAIN HIGH

A core mission of the VA Veterans Benefits Administration (VBA) is to provide financial disability compensation, Dependency and Indemnity Compensation, and disability pension benefits to veterans and their dependent family members and survivors. As of January 5, 2008, there was a backlog of some 406,000 rating claims with 105,693 cases waiting more than 180 days for decisions. These payments are intended by law to relieve the economic effects of disability (and death) on veterans and to compensate their families for loss. For these payments to effectively fulfill their intended purpose, VA must deliver them promptly and base such deliveries on accurate adjudications.

The need for financial support to disabled veterans is urgent. While awaiting action by VA on their pending claims, veterans and their families often suffer hardships, resulting in protracted delays that can lead to financial strains. Some of our "Greatest Generation" veterans have died after waiting for years for their disability claims to be resolved. What many classify as "The New Greatest Generation" faces the same situation in years to come if action is not taken immediately to address this broken system. In sum, VA disability benefits are critical. Meeting the needs of disabled veterans, especially those from OIF and OEF theaters of operation, should be a top priority of the federal government.

During Congressional hearings, VA has established timetables and benchmarks that continually change. This results in continual failure to meet the goal of identifying a long-term strategy in which VBA fulfills its mission and confirms the Nation's moral obligation to its disabled veterans. Congress as well as the Administration must continue to invest adequate resources, increase staff training, improve the electronic exchange of military records, and commit to a new strategy in order to improve quality, proficiency, oversight, and efficiency within VBA.

## DISABLED VETERAN EMPLOYMENT AND TRAINING SERVICE

According to Bureau of Labor Statistics, unemployment among recently discharged veterans is 11.9 percent, but for 18- to 24-year-old OIF/OEF veterans, the figure is 18 percent. What should raise serious questions is this: If the unemployment rate is this high for all veterans, what is the rate for seriously disabled veterans with sensory loss of blindness or deafness? Literature reviews on employment among persons with disabilities, and between the age of 18 and 61,

indicate that such persons experience lower labor force participation rates. Sensory-disabled Americans, for example, have a 47.1 percent employment rate. These findings are consistent across numerous national surveys, including the Current Population Survey (CPS), Survey of Income and Program Participation (SIPP), and the National Health Interview Survey (NHIS). They are also valid for several definitions of disabilities created during the past decade, including those that affect work capacity, activity limitation, or significant daily functional limitation.

Because a new generation of returning OIF/OEF disabled veterans is so directly affected by severe visual injuries, hearing loss, and TBI sensory loss, BVA requests that Congress work with VA and the Department of Labor on special demonstration employment projects for them. The Disabled Veterans Outreach Program (DVOP) and Local Veterans Employment Representatives (LVERs) should develop a specialized outreach initiative for disabled veterans with sensory loss, developing federal, state, and private agency employment opportunities. Transitional vocational training and employment assistance are critical to restoring disabled veterans and their families to financial security by returning them to full employment. Families can and should be included in this equation since most spouses, we have found, give up their jobs at least temporarily in order to become caregivers during the acute rehabilitation process. This process in some cases takes well over a year.

Another difficulty occurs when blinded veterans returning from OIF/OEF operations have performed jobs within the military that are highly specialized, technical, or entail an extremely narrow and specific set of duties and responsibilities. Examples of such positions include combat engineers, explosive ordnance specialists, special forces, and airborne operations. Even under the best of situations, such jobs are not easily transferable to the civilian sector. For this reason, the Center for Veterans Enterprise (CVE) needs additional funding and resources in order to assist disabled veterans in securing jobs in service-disabled, veteran-owned small business enterprises. We understand that although these cases require great effort and highly individualized services to our veterans, we also believe nevertheless that the talents and skills of our disabled veterans should never be overlooked or set aside.

## BLIND REHABILITATION CENTERS

After almost 61 years of existence and progress, Blind Rehabilitation Centers (BRCs) still provide the most ideal environment in which to maximize the rehabilitation of our Nation's blinded veterans. BRCs help them acquire the essential adaptive skills to overcome the many social and physical challenges of blindness. Despite the high-quality services and opportunities provided by BRCs, we discovered during FY 2007 that some BRC facilities had staffing shortages, leaving beds empty while waiting lists remained unacceptably high.

BRCs are especially important for returning OIF and OEF service personnel. Combat-blinded veterans suffer from multiple traumas that include TBI, amputations, neuro-sensory losses, PTSD (found in 44 percent of TBI patients), pain management issues, and depression (affecting 22 percent of those diagnosed with TBI). The aforementioned DVBIC (Defense Veterans Brain Injury Center) reports that an analysis of the first 433 TBI-wounded found that 19 percent had concomitant amputation of an extremity. Mild TBI was found in 44 percent of these 433 patients

and 56 percent were diagnosed with moderate-to-severe TBI. Some 12 percent of those with moderate-to-severe TBI had penetrating brain trauma. BRCs can and must deliver the entire array of highly specialized care needed for them to optimize their rehabilitation outcomes and successfully reintegrate into their families and communities. Mr. Chairman, we wish to strongly emphasize that private agencies may lack all of the highly specialized consultant services and prosthetics expertise that our residential blind centers have now developed. Only the inpatient VA BRCs have all of the diverse, specialized, and necessary consultant services such as prosthetics, orthopedics, neurology, rehabilitative medicine, and psychiatry to treat such service members and veterans. If private agencies must necessarily be utilized by VHA, we recommend that they be sanctioned by the Academy for Certification of Vision Rehabilitation and Education Professionals.

There is no environment of which we are aware that better facilitates the initial emotional adjustment to the severe trauma associated with the traumatic loss of vision than full, comprehensive blind rehabilitation. VHA BRS should have more control over blind center resources and funding levels. When and if this additional control occurs, BRS will be better able to track demand for workload across all centers, monitor waiting times, and improve the overall allocation of critical resources in meeting demand. With implementation of the Full Continuum of Care model announced by VHA, we again reiterate that greater emphasis will be placed on outpatient programs. Although this development is a positive one that improves access for blinded veterans, there is a significant possibility in the current structure and system of VISNs that some directors may attempt to mandate BRC directors to cut even more staff FTEE, reduce the number of inpatient beds, or limit the training inherent in these highly specialized programs. We fear that such action would hurt the quality and excellent reputation of BRCs.

## VISUAL IMPAIRMENT SERVICES TEAMS AND BLIND REHABILITATION OUTPATIENT SPECIALISTS

The mission of each Visual Impairment Service Team (VIST) program is to provide blinded veterans with the highest quality of adjustment to vision loss services and blind rehabilitation training. To accomplish this mission, VIST has established mechanisms to maximize the identification of blinded veterans and to offer a review of benefits and services for which they are eligible. The VIST concept was created in order to coordinate the delivery of comprehensive medical and rehabilitation services for blinded veterans. VIST Coordinators are in a unique position to provide comprehensive case management and Seamless Transition services to returning OIF/OEF service personnel for the remainder of their lives. They can assist not only the newly blinded veteran but can also provide his/her family with timely and vital information that facilitates psychosocial adjustment. Seamless Transition from DoD to VHA is best achieved through the dedication of VIST and Blind Rehabilitation Outpatient Specialist (BROS) personnel. VIST Coordinators are now following the progress of 102 blinded OIF/OEF veterans who are receiving services as outpatients.

The VIST system now employs 93 full-time Coordinators who work an average caseload of 375 blinded veterans. VIST Coordinators nationwide serve as the critical key case managers for some 44,700 blinded veterans, a number that is projected to increase to 52,000 within five years. It is

our belief that, as the current system transforms into more outpatient programs, VA should increase the number of full-time VIST Coordinators. We commend Congress and VA for creating and funding 11 new full-time VIST Coordinator positions. They are a critical component in the coordination of various services. We have found over the years that many VIST Coordinators have been assigned as part-time Coordinators, handling ever-increasing workloads. This limitation is a significant barrier to the individual charged with directing hundreds of blinded veterans to efficiently utilize the variety of services available to them.

The VIST/BROS teams will be able to provide improved local services when a veteran cannot attend a BRC. Given the demographic projections of visually impaired and blinded veterans, BVA believes and has always maintained that any VA facility with 100 or more blinded veterans on its rolls should have a full-time VIST Coordinator. BVA has found that the lack of VIST services is often due to the actions of local facility managers who seek to avoid the cost of even one FTEE. With the number of veterans treated at local VA Eye Clinics increasing to approximately 1,980,000 patient encounters last year, the VISTs and BROS are vitally important in VA's ability to meet the growing challenges inherent in these workloads. Veterans attending BRCs often require additional training later due to changes in adaptive equipment or technology advances. VISTs and BROS ensure that such training occurs. Thanks to passage of the aforementioned BROS legislation during the last session of Congress, VA BRS will attempt to establish 20 new BROS positions during FY 2008 in facilities throughout the system. The creation of these additional BROS will provide VA with an excellent opportunity to deliver accessible, cost-effective, top-quality outpatient blind rehabilitation services.

ADVANCED BLIND REHABILTATION PROGRAMS: VISOR

Pre-admission home assessments, individualized evaluations, outpatient setting training, all of which are complemented by a post-completion home follow-up, are part of VA's Advanced Outpatient Blind programs. Referred to historically as VISOR (Visual Impairment Services Outpatient Rehabilitation Program), an outpatient, nine-day rehabilitation experience, the Advanced Programs offer skills training, orientation and mobility, and low-vision therapy. The programs combine many of the features of a residential blind center with those of outpatient service delivery. A VIST Coordinator with low-vision credentials manages the program. Other key staff consists of certified BROS Orientation and Mobility Specialists, Rehabilitation Teachers, Low-Vision Therapists, and a part-time Low-Vision Ophthalmologist.

According to VA Outcomes Project Research, patient satisfaction with VISOR was close to 100 percent. VIAB's report recommended and endorsed a plan for this delivery model to be replicated within each VISN Network that does not currently have a BRC. The program uses hoptel beds to house veterans so that the beds do not require 24-hour nursing coverage. The experience is similar to staying in a hotel. BVA expects these new programs to significantly improve services, provide high-quality rehabilitative services, reduce waiting times, and decrease travel across networks for veterans.

INTERMEDIATE LOW-VISION PROGRAMS: VICTORS

Another important model of service delivery that does not fall under VA BRS is the VICTORS program. The Visual Impairment Center to Optimize Remaining Sight is an innovative program operated by VA Optometry Service. It consists of special services to low-vision veterans, who, although not legally blind, suffer from severe visual impairments. Veterans must usually have a visual acuity of 20/70 through 20/200 to be considered for this service. The program, entirely outpatient, typically lasts five days. Veterans undergo a comprehensive, low-vision optometric evaluation. Appropriate low-vision devices, sometimes several in number, are then prescribed. This process is subsequently accompanied by necessary training with the devices so that independence in daily life can be maximized.

The Low-Vision Optometrists employed in the program known as VICTORS are ideal for the highly specialized skills necessary for the assessment, diagnosis, treatment, and coordination of services for returnees from Iraq or Afghanistan with TBI visual dysfunction and who require low-vision services. The Palo Alto VA Polytrauma Center and Eye Clinic, for example, have already initiated the screening of OIF/OEF veterans for PTVS. The Intermediate Low-Vision Programs being planned and implemented will assist in the growing rehabilitation needs of aging veterans with degenerative eye disease. The programs enable working individuals to maintain their employment and retain full independence over their lives. Legally blinded veterans who have already attended a residential BRC and received specialized low vision aids, and who then require minor modifications, will benefit from these intermediate outpatient programs. They will allow for testing the effectiveness of new technology aids through review, research, and the writing of new prescriptions when appropriate. Programs such as the new Advanced and Intermediate Low-Vision programs are cost effective in improving access and quality care for high-need, low-vision veterans with residual vision from conditions such as macular degeneration, diabetic retinopathy, and other co-morbidities in improving access and quality care.

## VA RESEARCH

Further exacerbating the inadequate funding for research is that the budget of the Rehabilitation Research and Development Service, one of the four components of the Office of Research & Development within VA, has recently been trimmed in favor of other priorities. In FY 2008, Congress increased the amount to $480 million. VA requested only $442 million for FY 2009, hoping that the Department could locate additional sources of research funding. We again believe this to be unconscionable at a time when severely disabled service members are returning from war zones and need the very finest in research, training, and rehabilitation care. BVA feels that $442 million is unacceptable in view of the large increases in combat injuries.

Future research could potentially preserve sight, restore lost functions, and/or prevent further deterioration. BVA endorses the recommendation of Friends of VA Research (FOVA) that the VA Medical and Prosthetics Research Program receive a total of $555 million in FY 2009 in order to keep pace with biomedical research cost increases. The Biomedical Research and Development Price Index (BRDPI) for FY 2008 is projected to be 3.4 percent. BVA also strongly supports the National Association of Eye Vision Research (NAEVR) position that eye and vision research funding be expanded in the DoD/Congressionally directed Peer Reviewed Medical

Research Program (PRMRP). The program received funding for six research projects this past year. We request, for FY 2009, an increase above the $50 million authorized for FY 2008 because of the large numbers of combat eye-injured returning from OIF and OEF.

## OVERSIGHT

Mr. Chairman, oversight hearings by the House VA Subcommittee on Health should be held on the subject of DoD and VHA screening, diagnosis, and tracking of OIF and OEF service members with TBI-related visual complications. The recent GAO TBI Report (GA-08-276), released in February 2008, raised some questions about the general screening being done. BVA has been unable to find numbers from the four VA Polytrauma Centers on the specific screening of TBI patients found to have neuro-sensory visual dysfunction although most experts have suggested that 45-65 percent of all TBI patients have PTVS.

The establishment and progress of the DoD/VA Military Eye Trauma Center of Excellence and Eye Trauma Registry should also be carefully overseen. With approximately 1,200 combat eye-injured having been evacuated from OIF and OEF operations, another 3,000 moderately eye-injured returned to duty, and an estimated 4,000 TBI-wounded with a high probability of visual dysfunction, follow-up from Congress is critical. BVA questions why every TBI center within VHA does not have a low-vision optometrist and an ophthalmologist assigned at least part-time to the specialized staff.

## CONCLUSION

Once again, Mr. Chairman, thank you very much for the opportunity to present the Blinded Veterans Association's legislative priorities for 2008. Despite all that has been said and written about the progress that has been made, BVA is still extremely concerned that all blinded veterans have future access to the full continuum of services discussed here today. We are especially mindful, at this particular time, of our returning service personnel from Iraq and Afghanistan with visual injuries that will require long-term, specialized rehabilitative services. We again request that the new Military Eye Trauma Center of Excellence have directed funding, resources, and careful oversight during implementation.

The future strength of our Nation depends on the willingness of young men and women to serve in our military, and that depends in large part on the willingness of our government to meet its obligation to them as veterans. Waiting will only increase the problems and expenses associated with this crisis. Thank you again, and I will gladly answer any questions you or other Members of these Committees may have concerning our testimony.

## RECOMMENDATIONS

1. Making veterans health care funding sufficient, timely, and predictable is inextricably linked to eliminating the need for Continuing Resolutions and Supplementals, both of which delay care to veterans in the long run. BVA strongly endorses the VSO Independent Budget recommendation that funding for veterans health care be removed from the discretionary budget process and

converted to a new appropriations model. Until this proposal becomes law, however, Congress and the Administration must ensure that VA remains fully funded by means of the discretionary process.

2. BVA should identify strategies to develop screening, diagnosis, education, and research in the area of TBI that are related to visual dysfunction. An authorization of $4 million for Post-Trauma Vision Syndrome should go to VHA for joint VA/DoD Traumatic Brain Injury Optometric program screening. Research into the long-term consequences of mild-to-moderate TBI visual dysfunction in OIF/OEF veterans, as well as similar injuries in previous generations of combat veterans, is critical.

3. Congress must ensure the establishment and funding of the Military Eye Trauma Center of Excellence and Eye Trauma Registry and that joint DoD/VA resources will be available for its success thereafter. DoD/VA should also implement specialized low-vision optometric and neuro-ophthalmology screening of veterans in conjunction with other proposed centers of excellence in the area of TBI and PTSD.

4. Congress should mandate, with time benchmarks, a single, bi-directional, electronic health care records system for a truly efficient Seamless Transition. DoD and VA must also implement a mandatory, single-separation physical examination as a pre-requisite to prompt completion of the military separation process.

5. BVA endorses the recommendation of Friends of VA Research (FOVA) that the VA Medical and Prosthetics Research Program receive $555 million in 2009 to keep pace with biomedical research cost increases. BVA also strongly supports the National Association of Eye Vision Research (NAEVR) position that eye and vision research funding must be expanded in the DoD/ Congressionally directed Peer Reviewed Medical Research Program (PRMRP). The Association requests an increase above the $50 million authorized this year because of the large numbers of combat eye injured returning from OIF and OEF.

6. BVA is grateful that the beginning stages of the new outpatient blind and low-vision programs within the "Full Continuum of Care" for veterans were implemented in FY 2008. The FY 2009 proposed VHA budget includes an increase of only $5,987,000. For FY 2009, BVA requests the necessary $14.5 million that has been promised for full implementation of the continuum.

7. Legislation that would amend the Beneficiary Travel Regulation in Title 38 should be introduced. BVA believes that VA should be allowed to pay for the transportation of catastrophically disabled veterans who are accepted to one of the VA special disabilities programs and who are currently not eligible for travel benefits. Such veterans are already required to pay the Social Security Administration co-payment and a daily per diem rate during the rehabilitation period. Adding the burden of travel costs, which usually involves air transportation, serves as a strong disincentive to taking advantage of the world-class rehabilitation services offered by VA.

8. The Disabled Veterans Outreach Program (DVOP) and Local Veterans Employment Representatives (LVERs) should develop a specialized outreach initiative for disabled veterans with blindness or low vision. The program should demonstrate federal/state/private employment

opportunities. Transitional vocational training and employment assistance are critical if disabled veterans and their families are to be returned to full employment and financial security.
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9. BVA advocates a full Cost-of-Living-Adjustment (COLA) for veterans receiving disability compensation and for surviving spouses and dependent children receiving Dependency and Indemnity Compensation (DIC).

10. BVA supports the VSO Independent Budget's recommendation for changes in burial allowance benefits. The IB recommends increasing the plot allowance from $300 to $745 and expanding eligibility to all veterans eligible for burial in a national cemetery, not just those serving during wartime. BVA also supports the recommended increase in the service-connected burial benefit from $2,000 to $4,100 and the increase in the nonservice-connected benefit from $300 to $1,270. These modest increases will result in more meaningful contributions to the burial costs of our veterans.

11. Congress should enact Concurrent Receipt legislation to totally repeal the inequitable requirement that veterans' retirement pay, based on longevity, be offset by an amount equal to their VA disability compensation.

12. Congress should also repeal the currently inequitable requirement that the amount of an annuity under the Survivor Benefit Plan be reduced on account of, and by an amount equal to, the amount received by a veteran under Dependency and Indemnity Compensation.

13. All DoD MTFs should use the VIST/BROS teams as key points of contact on behalf of any service personnel with blindness or low vision. Any VA Medical Center with more than 100 blinded veterans should staff one full-time VIST Coordinator.

14. The Senate Committee on Veterans Affairs should pass the Senate version, S. 1672, of the Vision Impairment Specialist Training Act, or H.R. 1240. The legislation would make VA BRS employment much more attractive to university students majoring in a field related to blind rehabilitation. The demand for high-quality Orientation & Mobility Specialists and Blind Instructors is currently very high due to the large numbers of aging blinded veterans and the increasing numbers of eye-injured OIF/OEF veterans entering the system.

15. H.R. 649, "The Blind Veterans Fairness Act," was passed in the first session of the 110th Congress. The legislatures of New York, New Jersey, Pennsylvania, and Massachusetts currently provide a yearly annuity for blinded veterans who have sustained a total loss of sight as a result of service in any war. Under current law, however, lower-income blinded veterans may actually lose part of their VA pension benefits for receiving this modest annuity from the state. This is a serious injustice for which additional legislation is necessary to remove the offset.